Feature of the Month: November

Reduce your chances of an eligibility denial by using the Recipient Eligibility Verification System (REVS)!

Saving time with REVS

Every week, providers see their claims denied for reasons related to the lack of, or faulty, member-eligibility verification. To avoid these errors, providers should use REVS to verify member eligibility before providing services. When using REVS to check eligibility, remember to view ***all*** of the information displayed, including coverage types that may require you to follow specific instructions.

Common REVS Denials

Listed below are the error codes for some of the most common eligibility denials that can be ***avoided*** if REVS is checked before providing services. (These percentages are based on the number of denials related to member eligibility, not a percentage of the total amount of denied claims.) To review descriptions of the error codes, refer to Part 6 of Subchapter 5 in your MassHealth provider manual.

REVS may be accessed at www.massrevs.eds.com.

004 & 010: INVALID MEMBER ID NUMBER (10.5% of claims are rejected for this error.)

Resolution: To avoid this error, always verify the member's identification number (RID) before billing MassHealth. Verifying the member's eligibility with REVS before billing for the date the service is provided, will confirm that the RID is correct.

The member identification number is the 10-character number that is printed below or beside the member's name on the member's MassHealth card.

237: MEDICARE PRESENT (8.75% of claims are rejected for this error.)

Resolution: Always verify member eligibility on REVS. Submit the claim to Medicare. Medicare will forward both paid and denied claims to MassHealth electronically for processing as part of the Coordination of Benefits Agreement (COBA). Additional information about COBA is available at the following link: Important Information About Medicare/MassHealth Crossover Claims.

246: MEMBER IS NOT ELIGIBLE ON THE SERVICE DATE (10% of claims are rejected for this error.)

Resolution: Always verify member eligibility on the date of service.

Along with checking REVS on the day services are provided, hospitals should check REVS each day a member is an inpatient, as coverage for members can change while they are in the facility.

484: COVERAGE IS BUY-IN/SUBSIDY ONLY (11.5% of claims are rejected for the following coverage type errors.)

486: SERVICE IS NOT COVERED BY BASIC COVERAGE TYPE

487: SERVICE IS NOT COVERED BY MEMBER COVERAGE TYPE

488: SERVICE IS NOT COVERED BY LIMITED COVERAGE TYPE

489: SERVICE IS NOT COVERED BY FAMILY ASSISTANCE COVERAGE TYPE

Resolution: Always verify member eligibility and coverage type in REVS as some coverage types have restrictions. Please refer to the Provider Regulations located in the MassHealth Provider Library for details of what is covered for specific coverage types.

516: MEMBER HAS OTHER INSURANCE (10.5% of claims are rejected for this error.)

Resolution: Always verify member eligibility before the date of service and bill the other insurance before billing MassHealth. Claims submitted after other insurance has been billed may be billed using the electronic Coordination of Benefits (COB). These claims do not require paper copies of the other payers' Explanation of Benefits.

For more information on COB billing, visit the Claims with Attachments page on the MassHealth Web site.

522: MEMBER IS INELIGIBLE ON SERVICE DATE (9.6% of claims are rejected for this error.)

Resolution: Always verify member eligibility before the date of service. Do not bill claims to MassHealth if the member is not eligible. Along with checking REVS before each time services are provided, hospitals should check REVS each day a member is an inpatient, as coverage for members can change while they are in the facility.

536: INVALID REFERRAL FOR MANAGED CARE SERVICE (9% of claims are rejected for this error.)

Resolution: Access REVS to verify the name and telephone number of the member's primary care clinician (PCC) and then contact the PCC to obtain the correct referral number. It is important to verify this information for each date of service as the member's PCC may change.

Note: If REVS indicates that the member is enrolled in a group practice, the first two digits of the referral number will typically be "97."

537: MANAGED CARE REFERRAL NUMBER IS REQUIRED (8% of claims are rejected for this error.)

Resolution: Access REVS to verify the name and telephone number of the member's PCC and then contact the PCC to obtain the referral number to enter on the claim.

983: SERVICE COVERED BY MANAGED CARE ORGANIZATION (8.75% of claims were rejected for this error)

Resolution: Use REVS before providing services to verify the member's coverage. The member is enrolled in a Managed Care Organization (MCO) and the service provided is covered by the MCO.

If any of your denied claims on your remittance advice are for one of these codes, using REVS could help you avoid these issues in the future. Next time, check REVS and you may prevent unnecessary claim denials!